

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgement before publication.

Immunization for Measles

TO THE EDITOR: In "Measles Transmission in Medical Facilities"¹ in the March issue, Drs Dales and Kizer recommend "routine immunization of new medical facility staff members born since 1956 . . . who lack documentation of prior immunization or disease," because "serologic surveys in California have indicated that, currently, perhaps 10% to 15% of young adults (ages 18 to 22 years) are susceptible to measles." This would apply where there is a lack of an immunization record showing month and year of immunization or where the diagnosis of measles was not made by a physician. I question the need for that recommendation, because more than 90% of those who will be subjected to immunization are already immune.

In the prevaccine era, more than 90% of all Seattle area measles cases occurred among children under the age of 9 and the median age was 5.5. There were large measles epidemics in the 1966-67 and the 1968-69 measles epidemiologic years and lesser outbreaks occurred in later years. Live virus vaccine was extensively introduced through a school immunization program in the fall of 1967 and the program was carried out subsequently for several years. In the 1970s and 1980s, passage of state immunization requirements resulted in immunization of many susceptibles who had slipped through earlier plus the reimmunization of many children who could not adequately document previous immunization.

Would it not be more cost effective and equally efficacious to focus their recommendation upon areas where measles cases have been introduced and accept an adult's statement that he or she has had the disease and the vaccine? Most diagnoses of measles cases were not called to the attention of a physician during the years when measles was epidemic and persons over the age of 22 are unlikely to have any immunization records to prove that they were immunized. Moreover, at least half of the physician-diagnosed measles cases during the recent postvaccine era have proved to be wrong.

In the example cited, it should be noted that in 64% of the cases the patients were of school age or younger and most of them had not been previously immunized. Had they been, the outbreak might also have stopped before ten generations. There is a good chance that it would have stopped at one or two generations.^{2,3}

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REFERENCES

1. Dales LG, Kizer KW: Measles transmission in medical facilities (Public Health and Preventive Medicine). *West J Med* 1985 Mar; 142:415-416
2. Fox JP, Elveback L, Scott W, et al: Herd immunity: Basic concept and

relevance to public health immunization practices. *Am J Epidemiol* 1971 Sep; 94:179-189

3. Amler RW, Bloch AB, Orenstein WA, et al: Imported measles in the United States. *JAMA* 1982 Nov 5; 248:2129-2133

Upright KUB Roentgenogram

TO THE EDITOR: I am one of the authors of the article "Spontaneous Colonic Drainage—A Rare Complication of an Amebic Liver Abscess" that appeared in the February issue.¹ I would like to correct a typographical error in one of the figures.

On page 254, Figure 2, right picture, the caption reads "Another upright chest roentgenogram taken immediately after the episode of diarrhea." The caption should read "An upright KUB roentgenogram taken immediately after the episode of diarrhea."

Please bring this correction to the attention of your readers.

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REFERENCE

1. Armen RC, Fry M, Heseltine PNR: Spontaneous colonic drainage—A rare complication of an amebic liver abscess. *West J Med* 1985 Feb; 142:253-255

Holmesian Skills in Medicine

TO THE EDITOR: My imagination was captured by Sherlock Holmes when I was a child. It was a joyful occasion when in medical school an esteemed professor led me in a Holmesian exercise in observation and deduction at the bedside. At that moment medicine became fun. Since that time, I have carried the same exercise to generations of medical students. We spend two minutes at the bedside in the intensive care unit, no touching or talking allowed. We then go out of sight of the patient and deduce the case history—which is always possible if the instructor uses his or her own powers of observation in choosing a patient. Most of my students react as I did.

"The faculty of deduction is certainly contagious." The reason for its contagion lies in the joy of seeing that which one might easily have overlooked and the power of deducing important conclusions from an instantly available fact. The charm of Sherlock Holmes is the joy he derived from making obvious that which to others was obscure. He made joy out of discipline where others made only drudgery.

There is accomplishment in mastering medical discipline, to give a complex medical presentation through to the last detail of a system review without omitting a significant detail. But there is joy in observing (as opposed to seeing, of course) the body language that says that a patient is getting well, or the small sign that makes a difficult decision easy. The disci-